THE RHODE ISLAND MEDICAL JOURNAL

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ORIGINAL ARTICLES

THE PRESIDENT'S ANNUAL ADDRESS*

By Roland Hammond, M.D.

Providence, R. I.

The By-Laws of this Association require that the President shall deliver an address at the Annual Meeting with special reference to the work and needs of the Association. During the seventy-eight years of its honorable existence seventy-eight addresses have been delivered, each differing with the personality of its author. Some have adhered to the mandates of the By-Laws, others have read a purely scientific paper, while many have pointed out the glorious achievements of the members of a previous generation.

This evening I should like to contemplate with you the possible future of this Association and its members a generation hence.

The Association is in a healthy condition, except for the fact that it should include in its membership a larger number of the regular physicians of the community. The meetings are well attended and the programmes deal with a wide range of subjects. The social hour following the meetings serves to promote good feeling, and sees the beginning of new friendships and the cementing of old ones. We are performing our function as a scientific and social society, but we are not abreast of the times in our relation to public health and welfare work. This may be described as the economic function of the district society. The physician can no longer maintain a passive attitude in public affairs. If he allows his prerogative to be usurped and shirks his duty, he throws wide open the door for paternalism and state medicine.

Although surrounded by quacks and charlatans and engaged in competition with irregular practitioners, the physician continues to be the court of last resort by the public at large in cases of serious illness. More than ever is he consulted by the intelligent layman for minor ailments and the beginnings of more serious maladies which may be checked or alleviated by timely intervention. As the value of medical treatment in the early stages of disease becomes more and more impressed upon the public at large, physicians will find greater fields of usefulness open to them.

But the public is constantly demanding better training among physicians, and rightly so. Medicine is a science, although unfortunately not an exact one, and rests upon the foundation stones of research and experiment. Unless we are prepared to avail ourselves of the advances in science constantly being brought forward, we cannot hope to maintain medicine on the exalted plane on which it has rested for centuries.

The clinician of the future should be taught certain facts by a full time scientific worker, but his greatest instruction should come from one who is a practising doctor, well grounded in facts and trained in laboratory and clinical methods. Specialties may be further sub-divided for purposes of instruction for intensive work in one subject. More attention should be given to contact with the patient and family. This has always been a weak point in medical education and usually has been learned by bitter experience. Of late years emphasis has been laid upon scientific facts and laboratory data at the expense of the patient's peace of mind, as well as that of his family and friends, to say nothing of the actual treatment of the case in hand. A return to the old relation of preceptor and student, in a modified form suited to present day requirements, would be a very desirable addition to our medical school and post-graduate curricula. The attempts at post-graduate instruction in this State have been well received and should be continued.

In the midst of the present social upheaval one may well wonder what position the physician will eventually occupy in the scheme of things. This all depends on our own conduct. We should take lessons from other guilds and pin our faith upon intelligent organization. If physicians are to assume that leadership necessary to medical progress they must evolve an outline of purpose, a constructive, forward-looking programme of

*Read before the Providence Medical Association, January 3, 1927.

things to be done and of methods by which co-operation on the part of the public must follow their leadership. It may be expected that rules and regulations both of the state and federal government will continue further to embarrass both physician and patient. State medicine, government medicine, socialized medicine,—call it what you will—may continue to expand until the majority of physicians and of people as well will become elements in some vast government machine; but even so, private individual arrangements for personal and family health service are likely to continue indefinitely to demand skillful physicians to care for the most intelligent members of society so long as a vestige of personal liberty exists.

In countries where medicine has become largely a government function, the individual who can select and compensate his own physician on a personal basis still is the envied citizen, and the physician who gives only such service is the envied one among his colleagues. The opportunities to serve that portion of the public who desire medical service although surrounded by government regulations, enforced by salaried inquisitors, will probably continue as the method of choice of the elect and a goal well worth striving for by worth while physicians.

To quote from an editorial in the Journal of the American Medical Association for October 30, 1926:

"The intrusions and interferences are not of the physicians' choosing but are being forced increasingly on physicians and their clients by the unwarranted attempts at expansion of government into phases of personal health which violate every tradition of our people and are repugnant to those who serve and those served by a great profession.

"Society, acting through representative government, has responsibilities in medical and health matters as in other fields, but the line of demarcation between what is public and what is personal in matters of health must not be pushed back by government bureaus until government has invaded the privacy of the home and stands at the bedside of the individual."

It has been well said that there are too many medical meetings at the present time.

It may also be said that there are too many clinics. There can be no objection to the free clinic connected with established public hospitals. In other centres where medical schools exist such clinics are necessary for teaching purposes. In cities without medical schools these clinics serve an educational purpose in providing experience for the staff and in training leaders of the profession. The private clinic, of course, does not come under the scope of this discussion.

Many clinics are being established in this country and their number is rapidly increasing. In numerous instances the need of such clinics is questionable, and the aims of their founders should be open to searching scrutiny. For example: a certain group desires to erect a hospital of modern character. A survey of hospital conditions is made by an outsider, and the community is declared underhospitalized. A campaign is instituted, money raised, a hospital built and equipped, only to find that it is but partly utilized. The hospital supposed that it could draw upon a certain clientele, but the fickle public seeks hospital acommodations elsewhere and this charity leans upon the community for support.

Social service has developed so rapidly in this country of late years as to reach the dignity of a profession. In every community there are many kindly people who look upon social service with the fervor of religious zealots. The growth of wealth and prosperity in this country have made the people sensible of their responsibilities towards those less fortunate than themselves, and this has given an impetus to all forms of sociological endeavor. College students are taking up this work with the spirit of the crusader, inspired by professors who consider such service idealistic. They are alert to establish new forms of charity and their activities often center around clinics for the healing of the sick.

Professional social workers are rapidly supplanting zealous amateurs, and it is necessary for them to make good and to show results to their boards of directors, just as it is to be successful in any other calling in life. The result of this activity is that the highways and byways are combed for patients to fill these clinics. Duplication of effort follows. Several societies compete for the honor of assisting the same unfortunate individual to obtain medical aid or to rise in the world.

At the present time a wave of enthusiasm has spread over this country and to a lesser extent

the rest of the civilized world, for the purpose of alleviating the unfortunate condition of the crippled child. No more worthy object could be conceived nor one more likely to bear fruit in coming generations than this charity, fostered by kindly and enthusiastic people.

There are several organizations in this community working with the same idea in view to aid this class of dependents, but their activities are not co-ordinated. There is duplication of effort, and money is expended from several funds for the same purpose, which would not happen with better co-operation and efficiency. There are funds in this state for the relief of crippled children, the income from which is not being completely expended, because testamentary requirements must be complied with. Patients are being transported outside the State at large private expense for treatment in other institutions.

The moral of this tale is clear. How much better from every point of view if these various organizations should get together and pool their resources, making use of already existing local institutions, well equipped to take care of the medical treatment of these cases, and the social rehabilitation of the patients afterwards. Special funds and bequests could be established so that the identity of the donors would not be lost. There are numerous ways of securing the publicity so necessary for maintaining interest in these funds in future generations.

Funds donated or bequeathed by will should not be restricted to certain uses. Times change and customs with them, so that the charitable needs of one generation may be out of date in the succeeding generation.

Can the activities of several organizations, all seeking to accomplish one beneficent purpose, such as the care of one class of the indigent sick, be co-ordinated and put to better use? I believe so. This desirable end will eventually be achieved when the thinking public realizes that this duplication of effort and money involves a large economic waste.

Physicians are the only class who can view this problem from a correct angle and in its various aspects. We are best situated to know the need for more clinics. This Association might well go on record and require that no free clinics shall be established without first submitting plans to this Association or to the State Society for endorsement or rejection. Such plans should be comprehensive, showing the need of the proposed clinic, its location, the kind of people it intends to serve, the nature of the service to be rendered, an account of its methods of financing and a complete list of the members of the medical staff and the officials of the institution that is fathering it.

Special committees of the county and the State Society might be appointed to consider matters of this kind and in case such a clinic is endorsed, the committee could serve the clinic in an advisory capacity.

These same committees could serve a most useful purpose in helping to co-ordinate the activities of various social organizations so that there will be more efficiency in their work and less duplication of effort, with the resultant saving of both time and money.

Not the least of the disasters of free clinics is that in too many instances they serve, not patients who cannot pay for services, but a grafting and self-pauperizing element who will not pay.

A potent, readily available remedy is within control of county and state medical societies.

Why not use it?

REPORT ON A METHOD FOR TREATING FRACTURE OF THE FEMUR*

By Drs. P. P. Chase and Charles O. Cooke

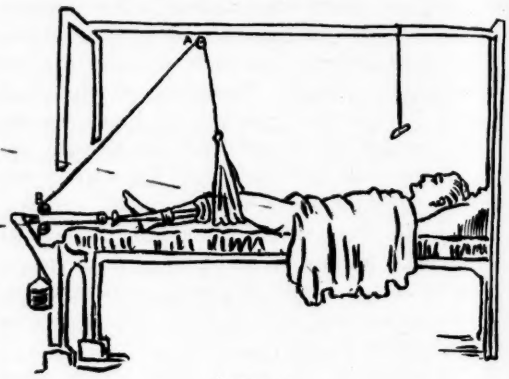
Providence, R. I.

Last fall Dr. Cooke and others reported seeing in Philadelphia, a method of treating fracture of the femur which had been devised by Dr. R. Hamilton Russell of Melbourne, Australia, a very original minded person as is also shown by his views on the treatment of herniae. This method was spoken of so well by the Philadelphia men and is so simple in its general details that we immediately began to use it at the Rhode Island Hospital and several services have tried it out with more or less earnestness and enthusiasm. Fracture of the femur is a difficult and unsatisfactory thing to treat as is shown by the numerous methods enthusiastically advocated and the results achieved. There is necessarily a long stay in bed, frequently with much discomfort and even when the length and

*Read before the Providence Medical Association, Oct. 4th, 1926.

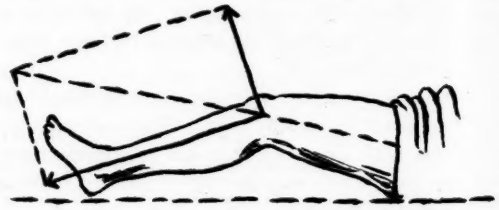
alignment of bone is good the stiffness of joints and muscles may linger for long periods. Hence suspension treatments with resulting freedom of movement for the patient have become popular and the smaller the amount of apparatus on the patient, the better, if it gets results.

When the femur is broken we find a shortening due to the tonic contraction of the muscles. If this is not combated, it steadily continues until there is great shortening and this is accompanied by much pain. It has long been recognized that a steady pull on the leg relieves the patient's discomfort. Formerly adhesive straps for extension have been brought up the thigh to the point of fracture or higher. This was because all the muscles were supposed to be pulling up the lower fragment and a pull entirely below the knee, it was feared, would put a heavy strain on the ligaments. Russell points out that the shortening force is practically all in the hamstrings and the rectus femoris which attach to the tibia and fibula. The lower fragment of the femur has little pull upon it and hence the knee ligaments will not be stretched. This is corroborated by war experience where the emergency dressing for fracture of the femur had its pull from the ankle. The men did not complain of a pull on the knee and it apparently was not injured. When we manipulate a leg for examination in a fracture case, we find that we put one hand under the knee and pull up and somewhat toward the foot, the other hand grasping the ankle and pulling in the line of the lower leg. The knee is now somewhat bent and a steady pull in this manner will probably keep the patient from complaining. Russell now devised an apparatus to embody these principles. He puts adhesive extensions on either side the leg from the knee to the ankle and from them straps are attached to a spreader beyond the foot. The knee is then suspended in a sling and from this a cord runs up to an overhead pulley vertically over a point a few inches below the knee. From here the cord runs over a pulley on a bar at the end of the bed, then to a pulley on the spreader at the foot and back over a second pulley on the bar and from the cord is attached the proper weight which may be as much as eight pounds for an adult. Pillows are now placed under the thigh and leg so that the heel is just off the mattress and the thigh is kept from sagging at the point of fracture. You will see from the arrangement of pulleys that the extension in the line of the leg is theoretically twice that of the lifting force. These conditions are of course somewhat modified by the friction of the pulleys and cord. Now the end of the bed is elevated so that the patient's weight gives counter traction. See diagram No. 1.



No. 1

Russell gives a diagram, using the lines of traction for two sides of a parallelogram and making the line along the lower leg twice that of the upright. We find that the resultant of forces or the diagonal of the parallelogram is in the line of the thigh. Improper angles of traction will result in a pull not in the line of the thigh and hence not



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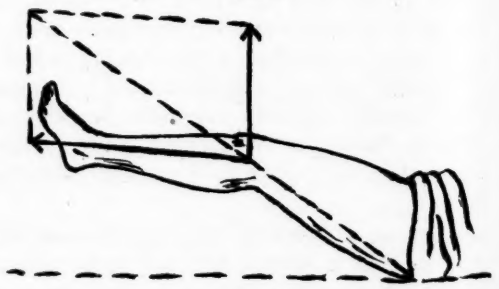

No. 3

be efficient. Russell states that when the adjustments are correct the suspension sling will prevent eversion of the lower leg. However, we have

found in many of our cases that we needed some pull to keep the foot inverted. Most methods for treating this fracture emphasize abduction as necessary, as muscular pull abducts the upper fragment. Russell states that when the limb is put in a natural and comfortable position, the upper fragment will take this position. In practice, we have found if there was a fault in alignment it was more apt to be an inward bowing, the upper fragment being adducted. Naturally the action of gravity will tend to a backward bowing at the seat of fracture and this must be well supported by padding with soft pillow.

In assembling the apparatus, use a light and flexible cord. Not much strength is necessary for a weight of eight pounds and much stiffness and friction on the pulleys modifies the interrelation of the pulls. For a sling, a soft rough towel has usually been used, but this is bulky and awkward, is apt to crease and cut under the knee and has a tendency to slide down the leg. Recently we have been using white felt which fits smoothly on the skin and clings in place.

Suspended over the patient's head is the usual sling by which he can move himself about. Formerly we were taught that in treating fractures of the long bones we should immobilize the joint at either end of the bone. With this apparatus, we not only leave the adjacent joints free, but encourage the patient to move his body. What actually happens probably is that the movement in the hip joint compensates leaving the bone fragments quiet. However, the opinion is prevailing nowadays that the lack of absolute fixation may rather encourage than retard union. Certainly the absence of heavy coverings and constriction must be helpful to the vitality of the limb.

Patients find this apparatus very comfortable. Last fall I saw a husky adult within 24 hours of admission, lying on his side and reading. The nurses report that the patients do not complain and nursing is made much easier. A continual complaint of pain means poor reduction. The only patient we had who could not get comfort had an open reduction and we found muscle interposed between the fragments.

The apparatus is easily and quickly applied and a general anesthetic is not necessary. One house officer claimed he could put up a case in ten minutes. He probably didn't time himself, but it is quickly done.

Of course the cases need watching; the pillows get displaced, the knee sling slips down, the foot may evert, the patient moves up and down the bed so that the traction weight may rest on something or the angle of the overhead change. Measurements of the leg length should be made at least daily.

Conclusions

1. This method carries out the manouvre by which in handling a broken thigh, we flex the knee, pulling it upward and slightly away from the body with one hand and with the other hand, make traction in the line of the lower leg. The resultant of these two pulls gives traction in the line of the thigh.

2. All the attachments are below the knee, the shortening pull on the lower fragment being practically all done by muscles attached to the tibia and fibula.

3. Through a cord running over four pulleys, one weight combines these tractions and comparatively small weights suffice.

4. The leg and thigh rest on soft pillows without constriction to the thigh, thus contributing to the comfort of the patient and the vitality of the tissues.

5. Alignment and length can be maintained despite changes in position of the patient's body. Thus, he is allowed freedom of movement which promotes comfort.

6. The apparatus is simple and quickly applied, anesthesia not being necessary.

7. Nursing is easy with this system.

8. Most methods give good results with children. This seems ideal because of its simplicity, comfort and the ease with which the patient is handled.

9. In adults, this extension seems efficient and its many advantages warrant a continued trial.

LOW BACK PAIN*

By Roland Hammond, M.D.
Providence, R. I.

It is a privilege to be asked by your President to address this Society and particularly upon such a common and yet little understood complaint. Backache is familiar to every practitioner and surgeon and is as common as indigestion or con-

*Read before the Kent County Medical Society, March 11, 1926.

stipation. In spite of a voluminous literature it remains in many cases an obscure and puzzling condition.

In considering low back pain it is first necessary to appreciate that in assuming the upright position man acquired several defects and weaknesses which did not trouble his quadrupedal ancestors. In man the viscera no longer hang at right angles to the vertebral column, but are suspended along side the spine. The anterior limbs do not serve as a support to the forward part of the vertebral column but hang from it and even require to be supported. In inspiration gravity assists rib movement in animals, while in man the ribs must be lifted against gravity. The lumbar lordosis of man is an acquired curve of the spine, since the backward curve of the dorsal spine is the only one present in animals. The most serious of these weaknesses is that found in the lumbo-sacral and sacro-iliac joints brought about by the upright position. These joints are held together only by ligaments and the natural roughness of their contiguous surfaces. There is no support of one bone upon another, as in the case of the knee or ankle, but the fifth lumbar vertebra may tend to slide forward from its resting place upon the upper surface of the sacrum. The movements of the lower back bring into play the largest and most powerful muscles in the body,—those of the back, shoulders, hips and thighs,—and consequently any pathological condition in the lower back is reflected over a large surface of the body.

The nerves involved in this area are among the largest in the body, and are subject to pressure from bone and soft parts as they emerge from the spinal canal and also in the pelvis.

Arthritis may involve the lower spine and pelvic joints and may occur as a part of a general arthritis or primarily in the spine. The symptoms accompanying this condition are often described as "lumbago." Movements of the spine are painful and the lumbar physiological curve may be flattened. Backache is also due to uterine, pelvic and abdominal causes or from metabolic or nervous disturbances, affecting the lower spine. The great majority of the cases with low back pain are due to sprains or injuries or to static deformities.

Traumatic backache involving the lower spine is usually due to sprain but occasionally may be caused by fracture of the transverse process of a vertebra with localized pain and stiffness on the injured side. Severer injury may result in compression fractures of the body of a vertebra. Such injuries are easily diagnosed by an X-ray examination.

Sprains of the spine may be comparatively simple, involving a muscular strain, or if due to external violence a ligamentous strain or rupture may be produced. Both lesions are exceedingly painful and disabling. The muscle strain may be expected to recover more quickly than the ligamentous injury which often requires a prolonged period of treatment.

In both conditions the symptoms are similar,—there is stiffness in side-bending and hyperextension of the spine, pain on sneezing or coughing, in riding over rough roads or when subjected to a sudden jar. Pain may radiate down the buttocks, thighs, and even to the calves and toes, and is distributed along the nerve roots, rather than in the course of the peripheral nerves. Lateral deviation of the spine may be present. X-ray is rarely of help in these injuries.

In the case of muscular sprains the pain and tenderness are more superficial and passive movements may be performed with comparatively little discomfort, while active movements are exceedingly painful. The ligamentous injuries are deep-seated, and can be elicited by spinal movements and pressure of the finger. It may not appear until several days have elapsed and both active and passive motions are painful.

In treating injuries to the back, the first indication is rest during the acute stage. Recumbency may be necessary or in mild cases strapping the back with adhesive plaster may be sufficient. As soon as pain and spasm have subsided, use of the back should be encouraged, always protected by a support. A small narrow webbing belt should be fitted and this should always be buckled in the back and never in the front or on one side. In women it is convenient and useful to attach the belt to a well fitting straight front and laced back corset. On account of the angle made by the sacrum with the ilium at the sacro-iliac joints, pressure from the wings of the ilia must be made backwards and inwards in order to approximate the joint surfaces. A pad over the sacrum has no mechanical effect. In a certain proportion of cases this treatment may be sufficient, but in the severer cases with symptoms of nerve pressure,

physiotherapy by means of diathermy or deep therapy lamp and followed by massage or vibration are of distinct benefit. In order to prevent the formation of adhesions, graduated exercises and manipulations of the spine should be carried out at the same time.

When adhesions have formed they should be broken down by forcible manipulations of the spine, either with or without an anesthetic. A small class of these injuries will need to be relieved by the above measures, particularly if there is any lateral curvature of the spine. These cases should be put into a well fitting spica, carried below the knee and coming well up onto the lower ribs. After two to four weeks in bed the spica may be removed and a belt or back brace of steel and leather substituted and exercises and manipulations employed. An anesthetic may be necessary to overcome lateral deformity of the spine or where there is much flattening of the lumbar curve.

In all injuries to the back the intestines should be cleaned out and diet supervised.

The prognosis of simple back strain is as good as in other joints, unless the patient is poorly muscled and has a defective posture or if there is a pronounced neurotic element. It must be remembered also that an injury to the back is associated with serious symptoms, such as pain and stiffness, out of all proportion to the injury. This is probably due to the proximity of the spinal cord to the injured part, to the fact that it is almost impossible to obtain perfect fixation of this part of the body, and because every movement of the trunk, thorax, legs and arms is felt in the spinal and pelvic joints. These cases often present a strong psychological element.

Static deformities in which there is erroneous deflection of the body weight are fairly common, and are due to various causes. In some cases there is a deviation of the trunk laterally, resulting from a lateral curvature of the spine or a short leg. In other cases the deflection is in an anteroposterior direction. The abdomen may be large and protuberant, or round shoulders may be present. Mechanical defects in the feet, such as, flat feet and short posterior leg muscles, may result in pain in the lower back. In addition are a few cases in which we are unable to find a cause.

Static backache presents many symptoms of a varied nature. They are associated with standing, walking, sitting and lying. Many women state that their backache has existed from childhood, growing more marked as they grow older. The pain is usually dull and grinding in character and apparently located at about the lumbo-sacral junction.

Many patients presenting these symptoms differ from the so-called normal type and may be divided into two well marked classes; (1) the slender, long waisted type and (2) the heavy, thickset and broad-backed type.

These patients should receive both general and local treatment. The general health should be brought up by hygiene, diet, outdoor life and suitable medication. Static errors should be corrected and some form of back support is usually necessary. In many cases foot errors should be corrected. Physiotherapy is particularly useful in this condition, and electric light baking and diathermy, massage or vibration and active gymnastic exercises are particularly helpful.

BOOK REVIEW

THE ORDEAL OF CIVILIZATION. *James Harvey Robinson.* Harper & Brothers, Publishers, 1926.

This book of 749 pages, for the most part history much condensed and selected to show its influence on the present, will prove perhaps too cultured for most of us. The last chapter, which considers "The Present Trend of Human Affairs," is exceptionally interesting, takes about five minutes to read, and will prove stimulating to anyone who deals with nervous and mental conditions. In it an excellent conception can be obtained of how the past makes the present, which is always a continuation of the past; of how by understanding the past we can understand ourselves, our emotions, our possibilities of achievement, our frustrations and perplexities, our scruples, obligations, conceits, prejudices, knowledge, and dexterities; of how all change in customs, individual or racial, is gradual; of how proximity accounts for much of our understanding of our fellows.

Our past, of course, exerts a tremendous influence upon our present; but I wish that the author had gone just a little farther and shown that, for all practical purposes, we ourselves determine whether the influence of the past shall be for good or for evil in our lives.

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RHODE ISLAND MEDICAL SOCIETY

Meets the first Thursday in September, December, March and June

H. G. PARTRIDGE	*President*	Providence
NORMAN M. MACLEOD	*1st Vice-President*	Newport
ARTHUR H. HARRINGTON	*2nd " "*	Howard
JAMES W. LEECH	*Secretary*	Providence
J. E. MOWRY	*Treasurer*	Providence

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Meets the second Thursday in each month

FENWICK G. TAGGART	*President*	East Greenwich, R. I.
J. F. ARCHAMBAULT	*Secretary*	Arctic, R.I.

NEWPORT

Meets the third Thursday in each month

WILLIAM S. SHERMAN	*President*	Newport
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PAWTUCKET

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R. I. Ophthalmological and Otological Society—2d Thursday—October, December, February, April and Annual at call of President Dr. J. J. Gilbert President; Dr. M. J. O'Connor Secretary-Treasurer.

The R. I. Medico-Legal Society—Last Thursday—January, April, June and October. Dr. Creighton W. Skelton President; Dr. Jacob S. Kelley, Secretary-Treasurer.

EDITORIALS

RADIO ADVERTISING OF NOSTRUMS

As an advertising medium for all sorts of commodities, radio broadcasting, while still in its infancy, has much to recommend it. Some day when the glamor of the fine performance of the new "set" no longer has its appeal we shall show greater discrimination in regard to the jazz and jargon which we allow to wreck the quiet of our homes. Until that time arrives the advertiser of anything whatsoever is assured of an audience and, like the magazines, the radio broadcasting concerns will derive their main support from the paid advertisements.

The manufacturers of nostrums have ever been willing to pay high prices, especially for space on the pages of supposedly reputable magazines. But the contributor of legitimate literature does not wish his articles to be seen in the same volume with notices which recommend worthless substances to gullible people. This is especially true of the authors of medical and other scientific articles, and in this country at least the appearance of an advertisement on the pages of any of

the better known medical or scientific publications is a practical guarantee of the honesty of its makers. But what of radio-advertising? The people of Providence at one time are being told simple medical facts by representatives of our State society, and the next day, and every day, are being urged to use "Salicon" as a sure cure for colds and other ills, or "Kaytonic," or whatnot other nostrum, for alleviation of various maladies real or imagined. The same radio station with laudable charity offers its services for the education of the public in matters of the preservation of health and then, with an eye on its bank account, sells the same privileges to be used for the purpose of possibly deluding and defrauding the same public by the unthinking recommendation of worthless nostrums. Can the public be counted upon to distinguish between the honest efforts in its behalf and the well disguised attempts upon its pocketbooks? Unfortunately it cannot. We may expect to hear people remark that the Rhode Island State Medical Society recommends both convalescent serum injections for the prevention of measles and "Salicon" for the prevention of colds, or antitoxin for the treatment of diphtheria and "Welldona" for rheumatism. What can be done? The JOURNAL believes that as a protest which may carry weight in the eyes of some of the more well meaning and public spirited directors of radio-stations, medical and scientific societies should refuse to authorize their members to broadcast from stations whose programs are known to include such advertising of nostrums as would not be acceptable on the pages of reputable medical journals.

MEDICAL EDUCATION IN RHODE ISLAND

With the opening of the splendid new Lying-In Hospital, the medical profession in Rhode Island sees another link forged in the chain of medical preparedness which for long we have all been striving. At the dedication of the new Lying-In Hospital we had the pleasure of listening to Dr. Newell, who stated that the value of a hospital to the patient and as a community service was increased if the hospital could be an active teaching center. Often before in these pages the question of medical teaching has been brought up. An active step has been taken during the past two years as a result of the courses offered to the medical profession in the various hospitals of the State. A question of a medical school in connection with Brown University has also been discussed, but should it end in discussion! Should not a committee be appointed from the Rhode Island Medical Society to co-operate with the proper officials of Brown University to study the whole matter and to see if a four years course in medicine in connection with Brown was logical and feasible. There is no question of the tremendous expense involved in such an undertaking, but has the State of Rhode Island the right to deny the splendid teaching experience offered in the hospitals of the State to prospective medical students and, especially, when we already have at Brown a premedical course of acknowledged high standing?

Let this question be viewed from every angle and let us appoint a committee whose advice we will be ready to accept after the situation has been adequately surveyed.

COMPARISON OF THE RESULTS OF VARIOUS TREATMENTS FOR ACUTE GONORRHEAL EPIDIDYMITIS*

ERIC STONE, M.D.

FROM THE UROLOGICAL CLINIC OF THE PROVIDENCE CITY HOSPITAL

This report is a study of 161 consecutive cases of gonorrheal epididymitis coming under my observation in private practice and on the wards of the Providence City Hospital between January 1921 and January 1926.

Six types of treatment were employed, sometimes more than one on a given case, in event of the initial treatment's failure to give relief. One hundred and eighteen cases received only what is here designated as the "Expectant Treatment" as their only form of therapy. Seven were treated by diathermy. On 36, epididymotomies were performed. Six received intravenous injections of mercurrochrome, four sodium iodide, and four received intramuscular injections of Aolan (a boiled milk preparation). The last three types

*Read at the April meeting of the Providence Medical Association, 1926.

of therapy were used as an adjunct to the expectant treatment.

Expectant Treatment

The expectant treatment consisted of rest in bed, support of the scrotum on an adhesive bridge across the thighs, 20% icthyol ointment applied locally b.d., cessation of urethral treatments, alkalies by mouth, "Gonorrhea Diet," ice bag constantly to the affected side and other medication as the constitutional symptoms indicated.

Three bases for comparison of the effectiveness of the treatments have been selected, the first two because of importance to the patient and the last because of its medical significance. They are, the number of days to the relief of pain required after treatment had been started, the numbers of days the patient was confined in the house or hospital after initiation of treatment and the length of time after commencing treatment to the involution of the epididymus. This last needs some explanation. The epididymus was considered involuted if it had gone down to the size of an ordinary baked bean and was free of all tenderness.

As most of the hospital cases were discharged to their original source they could not in many cases be followed to the final outcome, so where percentages are given the numbers of cases observed at each period are given at the head of the column.

The figures for the expectant treatment are found in Table I.

TABLE I.

Time to Relief of Pain		Time Incapacitated		Time to Involution	
No. Cases	118	118		70	
Per Cent.	Days	Per Cent.	Days	Per Cent.	Days
8.0	1	8.1	4	5	7
1.5	2	2.1	5	5	10
18.0	3	6.3	6	5	11
16.0	4	5.4	7	5	12
11.5	5	3.6	8	5	14
2.5	6	5.4	9	15	18
2.5	7	16.3	10	15	21
3.4	8	18.1	14	15	28
5.4	9	11.8	18	15	32
		.7	21	15	48
		.1	24		
		.1	28		
		.1	35		

Eleven percent received so little relief that other types of treatment were employed, these cases are further listed under the other type of treatment instituted.

In 10 cases or 9.9% there were recurrences of the epididymitis. One 10 days after discharge from the hospital, 5 occurred 14 days after discharge, 1 after 7 weeks, 1 after 10 weeks and one 3 months later.

Epididymotomy

Of 36 cases operated 50% had no pain whatsoever after the multiple puncture of the epididymus. See Table II.

TABLE II.

Time to Relief of Pain		Time Incapacitated		Time to Involution	
No. Cases	36	36		10	
Per Cent.	Days	Per Cent.	Days	Per Cent.	Days
50	Immediate	11.	2	20	7
12.5	½	13.9	5	20	14
10	1	8.3	6	10	18
2.5	4*	13.9	7	30	21
		11.	8	10	27
		11.	10		
		3.9	12		
		2.5*	21		

*This case developed a hæmatoma in the wound.

Four cases or 11% recurred, one for only a day, and did not incapacitate the patient.

Mercurochrome

Six patients received intravenous injections of 1% mercurochrome at 48 hour intervals, starting with 10 cc. for the first dose, 15 cc. for the second and if these were well tolerated 20 cc. thereafter. The urine was examined daily for albumen. Two cases showed it, one after the second injection and one after the third. With the appearance of albinuria the treatment was discontinued. See Table III for effects of the treatment.

TABLE III.

Time to Relief of Pain		Time Incapacitated		Time to Involution	
No. Cases	66	66		1	
Per Cent.	Days	Per Cent.	Days	Per Cent.	Days
30	¼	11	7	100	32
50	1	11	9		
11.5	2	39	12		
8.5	4	39	21		

In view of the interest in the reactions occurring under this form of therapy, they are recorded. One case had nausea or vomiting for an hour or

two after each injection. One developed a marked diarrhea after the first treatment, but none after the others. Two developed stomatitis, one after the second injection and the other after the third Four showed temperature reactions after each treatment, ranging from 102 to 103, but in no case lasting more than 4 hours. Two had no constitutional reaction following the treatments, they were the cases least benefited by mercurrochrome.

Sodium Iodide

Four cases received, in addition to the expectant treatment, sodium iodide 25 gr. intravenously at 48 hour intervals. 25% (1 case) was relieved at the end of 48 hours, 25% not until the end of the fourth day, 25% on the eighth day and one case was still in pain at the end of the eighth day and called in another physician who did an epididymotomy. One patient was incapacitated 6 days, one 9 days and one case left the hospital against advice on the 18th day. The final outcome of the case which escaped from my care I do not know.

Aolan

The same number of cases received Aolan in conjunction with the expectant treatment. Ten cc. of the foreign protein was injected deep into the gluteal muscles every second day. Three cases or 75%, were relieved on the first day, and the fourth on the second day. One was discharged on the second day, one on the 6th day, one on the 8th, and the last on the 13th. In one the epididymus was down to almond size and nontender on the 8th day, 2 or 50% by the 21st day and one by the 28th day. In one case there were two minor recurrences which did not require cessation of work.

Diathermy

Five cases were ambulatory, wearing a supporter during the day and applying support, icthyol and ice at night. They all received daily exposures to the high frequency current through the Corbus Bipolar Scrotal Electrode running for half an hour at 600-800 milamperes. In one or 20% no relief was experienced from the first treatment and at the patient's request an epididymotomy was performed and the case is further recorded under that heading. In one case the pain was completely relieved on the first day, in one on the second, in one on the fourth and in one on the fifth day. In two the epididymus was considered normal at the end of the second week, in a third at the end of the third week, (40 and 20% respectively). In one case the epididymitis recurred two weeks after the subsidence of pain.

Comment

Epididymotomy gave almost instant relief in 50% of the cases. In 97.5% the pain had disappeared in 24 hours, whereas expectant treatment gave relief to only 8% in 24 hours and 18% only were relieved by the 3rd day. Mercurrochrome gave relief to 33 1-3% within 6 hours, to 50% by the end of the 1st day and none had pain after the 4th day. Sodium Iodide gave results comparable only to the expectant treatment. Aolan gave relief to 75% by the 24th hour and to 100% by the 48th hour, in this respect comparable to mercurrochrome and without any of the ill effects of the latter drug. Diathermy failed in one case, but in 80% of the cases the patients were saved any incapacity. However it must be admitted that these were selected cases, seen within 12 hours of the onset of pain and swelling. They were also all in men of sedentary occupation.

Of those treated by expectant means alone 11% received no relief and other methods were resorted to. Of those receiving this conservative treatment throughout the course of their illness 21.9% were discharged from the hospital on or before the 7th day, and 65.3% on the 14th day or during the second week. Where epididymotomy was performed 49% were discharged by the 7th day and 99.7% were discharged on or before the 14th day. Where mercurrochrome was used, 11% were discharged on the 7th day, and 65.6% during the 2nd week, figures closely resembling those for expectant treatment alone. All cases receiving Aolan were discharged by the 14th day and 75% by the 7th day.

As to sodium iodide the figures correspond to those for the expectant treatment alone. Diathermy gave no relief to one case or 20%, but 80% were not incapacitated at all.

Of those observed throughout the illness return to normal occurred among those receiving expectant treatment in one week in 5%, in two weeks in 20%, in three weeks in 35%, and by the end of the fourth week in the remaining 40%. Where surgery was done the figures are respectively 20%, 30%, 30% and 20%. Only one case in which mercurrochrome was used could be followed until cured, involution was down to our arbitrary normal by the 32nd day. In none of those receiving

sodium iodide was involution complete by the third week, after which time they no longer came for observation or treatment. Recovery took place in 25% of the patients receiving Aolan by the end of the 1st week, 50% by the end of the 3rd week and 25% by the end of the 4th week. Where diathermy was employed 40% were cured by the fourteenth day, 20% by the 42nd day. One case failed and in one a recurrence treated by expectant means obscured the results of diathermy alone.

Recurrences took place in 9.9% of those receiving expectant treatment, in 11.1% of those whose epididmymus was opened, none among the 6 receiving mercurrochrome, none among those receiving sodium iodide, in 25% of those receiving Aolan and in 20% of those treated by electricity.

Conclusions

It may be stated dogmatically that:

1. Expectant treatment alone is not sufficient.
2. Epididymotomy gives—
   a. Immediate relief of pain in a vast majority.
   b. Shortens hospitalization by half as compared with expectant treatment.
   c. Shortens the period to normality by half.
   d. Has a percent of recurrence well within the co-efficient of statistical error as compared with expectant treatment.

It may be stated tentatively that:

1. Mercurrochrome stands next to epididymotomy in relieving pain, shortens the time to cure, but does not shorten the hospital period. In most cases it has annoying secondary effects.
2. Sodium Iodide is of no benefit.
3. Aolan does not relieve pain as rapidly as either epididymotomy or mercurrochrome, but it does shorten the period of hospitalization to even as great an extent as epididymotomy.
4. In selected cases diathermy may obviate any incapacitation.
5. When a patient presents himself with this condition, if it is an early case and the patient's occupation is sedentary diathermy is a permissible method of attack. If the condition is advanced and the patient's work physically violent it may be wise to offer—
   a. Epididymotomy if social conditions demand early return to work.
   b. Aolan in conjunction with expectant treatment if the pain is moderate and earliest possible return to work is not imperative.

A note on the occurrence of epididymitis may be of interest. In private practice it appeared in 32 or 4.6% of 700 consecutive cases of acute or chronic gonorrhea.

SOCIETIES

RHODE ISLAND MEDICAL SOCIETY

HOUSE OF DELEGATES
SPECIAL MEETING, JAN. 7, 1927

A special meeting of the House of Delegates was held this day at 5 P. M. at the Medical Library, the President, Dr. H. G. Partridge, presiding.

Dr. Partridge reported on the activities of the New England Medical Council recently formed and stated that delegates from the Rhode Island Medical Society were desired. It was moved and seconded that the President and the Secretary be members of the New England Medical Council ex-officio and that the President be empowered to appoint the remaining three delegates. It was so voted and the President appointed:

L. C. Kingman, M.D.
F. N. Brown, M.D.
F. T. Fulton, M.D.

as the other delegates to the Council.

It was moved and seconded that the expenses of the delegates be paid by the Rhode Island Medical Society. It was so voted and the motion referred to the Council for action.

The matter of immediate medical relief in disaster as proposed by the American Medical Association was considered under deferred business. The Secretary read a communication from the Providence Chapter of the American Red Cross which showed that plans for medical relief in disaster are well organized for Providence but giving no information in regard to the other sections of the State. It was voted that the President be empowered to delegate the duties of the State Director of the Medical Relief in Disaster to the

Director of the Medical Relief of the Providence Chapter of the American Red Cross.

Adjourned.

J. W. LEECH, *Secretary*

PROVIDENCE MEDICAL ASSOCIATION

The regular monthly meeting of the Providence Medical Association was called to order by the Vice President, Dr. Henry J. Hoye, Monday evening, November 1, 1926, at 9 o'clock.

The records of the last meeting were read and approved.

Dr. Jameson reported a case and demonstrated the gall bladder removed by Dr. A. T. Jones.

Dr. John I. Pinckney of the Providence Tuberculosis League gave a Preliminary Report of a General Survey of the Primary Public Schools of Providence.

Out of over 15,000 children some few hundred children were found under weight and these cases were divided into reactors and non-reactors to skin tests. He could not find definite difference between these two groups in regard to appetite, spirits, efficiency in school work or physical examination.

This was a preliminary report of extensive work.

The discussion was opened by Dr. Gerber and continued by Drs. Perkins, Buffum and Pinckney.

The second paper was by Dr. Philip Batchelder on Uses and Limitations of X-Ray in Examination of the Head. He took up in detail most of the problems met with and showed a number of interesting slides. The discussion was opened by Dr. James F. Boyd and continued by Drs. Gerber McDonald, Donnelly, L. B. Porter, Adams, Kelly, Gerber and Batchelder.

The meeting adjourned at 10:40 P. M. Attendance 67. Collation was served.

Respectfully submitted

PETER PINEO CHASE

Secretary

The regular monthly meeting of the Providence Medical Association was called to order by the President, Dr. Roland Hammond, Monday, December 6, 1926, at 8:50 P. M.

The records of the last meeting were read and approved.

The Standing Committee having approved their applications the following were elected to membership: Lucy E. Bourn, Anthony M. Feifer, Anthony Romano.

The first paper of the evening was read by Dr. William A. Horan on Astragalectomy and Backward Displacement of the Foot.

He spoke shortly of the history up to the time when Whitman devised the operation which is now recognized as the approved method of stabilizing the foot in cases of flail foot and certain types of paralyses. He gave the indications, a short description of the technique and an excellent moving picture demonstration of the operation. Then he showed some interesting cases to illustrate the results.

The paper was discussed by Dr. Roland Hammond.

The second paper was by Dr. Morein on Diagnosis of Gall Bladder Disease. This can often be made on the history alone of indigestion in its many manifestations, biliary colic and jaundice. Physical examination is usually not very important, biliary drainage is generally not much esteemed, laboratory tests and liver function may help but the X-ray examination is worth all the others. This may show:

1. Failure to produce a shadow.
2. The negative shadow of gall stones.
3. Failure normally to expell the contents and
4. Distortion of shape of the bladder.

He showed some interesting films illustrating these points. The paper was discussed by Drs. C. O. Cooke, A. M. Burgess and I. Gerber.

The meeting adjourned at 11 P. M. Attendance 49. Collation was served.

Respectfully submitted

PETER PINEO CHASE

Secretary

The annual meeting of the Providence Medical Association was called to order by the President, Dr. Ronald Hammond, Monday evening, January 3, 1927, at 8:50 P. M.

The records of the last meeting were read and approved.

The reports of the Secretary, Treasurer, Standing Committee, Reading Room Committee. Milk Commission of the P.M.A. were read.

REPORT OF THE SECRETARY

The Providence Medical Association held nine meetings during the year 1926 with a total attendance of 591, which is eight less than last year and 75 less than the year before.

The total active membership Dec. 31, 1926, was 372.

For the four years before we entered the war the average total membership was 283 and the average total attendance was 698; that is, with about a third larger membership than we had then we have about a seventh smaller attendance. Six hundred forty-nine, the smallest attendance in any of those four years, has been exceeded only twice in the eight years since the war. It is evident that attendance on medical meetings is on the wane in this community. Two men were dropped for nonpayment of dues.

During the year the Association lost by death, George L. Collins, Frederick G. Phillips, George T. Spicer and Frank L. Day.

Nineteen applicants were elected to active membership.

Sixteen papers were read by members and four by guests and these papers were discussed by 83 members and guests. A striking feature of the meetings this year was the large number taking part in discussions; nearly half as many again as last year with the same number of papers. There were two case reports by members.

REPORT OF READING-ROOM COMMITTEE, 1926

Journals subscribed for by Providence Medical Association:

American Journal Obstetrics and Gynecology
American Journal Roentgenology
American Journal Syphilis
Archives of Dermatology and Syphilology
Archives of Pediatrics
Archives of Neurology and Psychiatry
Archives of Otolaryngology
Archives of Surgery
Brain
British Journal of Children's Diseases
British Journal Tuberculosis
British Medical Journal
Heart
Journal of Bone and Joint Surgery
Journal of Experimental Medicine
Journal of Industrial Hygiene
Lancet
Medical Journal and Record
Military Surgeon
Modern Hospital
Psychological Clinic
Quarterly Cumulative Index
Surgery, Gynecology and Obstetrics
Surgical Clinics of North America

FIRST ANNUAL REPORT OF MILK COMMISSION OF THE PROVIDENCE MEDICAL ASSOCIATION

The Milk Commission of the Providence Medical Association was appointed in December, 1925. The Commission belongs to the American Association of Medical Milk Commissions and has adopted the methods and standards established by that organization.

Through the co-operation of the Medical Milk Commissions of Boston and Worcester we have accepted the certification of the following farms:

1. Bonnie Brook Farm—H. P. Hood & Sons.
2. Walker-Gordon Laboratory Co.
3. Alta Crest Farms of Spencer, Mass.

During the past six months from June to November inclusive, we have supervised the sale of 30,000 quarts of certified milk in Providence. Weekly bacteriological and chemical examinations are made in the laboratories of Brown University under the supervision of Professor Gorham.

The results of these analyses are as follows:

	Alta Crest	Hood	Walker-Gordon
General average bacteria.....	3572	2202	3607
General average fat.....	4.13	4.49	3.91
General average total solids..	13.14	13.78	12.95
Highest bacteria count.....	8750	5000	9400
Lowest bacteria count.....	1700	450	650

The members of this Commission are as follows:

William P. Buffum, M.D., *Chairman*
Maurice Adelman, M.D.
William H. Jordan, M.D.
A. Roland Newsam, M.D.
Reuben C. Bates, M. D.,
Secretary and Treasurer

Dr. J. M. Peters announced the meeting to present Dr. Chapin's portrait to the State Society. Dr. Roland Hammond read the President's Annual Address, which sought to contemplate the possible future of this Association. Although we are in a thriving condition we are not abreast with public health and welfare work. No longer can we hold a passive position in public affairs or paternalism and state medicine will overwhelm us. We must keep in closer contact with the patient and family and thorough scientific training must be supplemented by instruction from practicing doctors.

Government control of medicine will probably increase but there will always be those who will insist on personal choice of physicians. Already there are too many free clinics and the professionalizing of social service leads to the abuse of this by those anxious to show results. Organization is conflicting and duplicating. Their resources should be pooled. And medical societies should supervise and regulate the proper distribution of this work.

The officers and committees for the ensuing year so nominated by the Standing Committee were unanimously elected.

In accordance with Article I, Section 6, of the By-Laws, the Standing Committee made the following nominations for officers and committees for the year 1927:

For President, Henry J. Hoye, M.D.

For Vice-President, Edward S. Brackett, M.D.

For Secretary, Peter Pineo Chase, M.D.

For Treasurer, Charles F. Deacon, M.D.

For Member of the Standing Commitee for five years: Roland Hammond, M.D.

For Trustee of the Rhode Island Medical Library for one year: Frank T. Fulton, M.D.

For Reading Room Committee: George S. Mathews, M.D., Elihu Wing, M.D., Guy W. Wells, M.D.

For Delegates to the House of Delegates of the Rhode Island Medical Society: W. F. Flanagan, M.D., M. B. Milan, M.D., H. B. Sanborn, M.D., L. C. Kingman, M.D., E. S. Cameron, M.D., W. H. Higgins, M.D., A. J. McLoughlin, M.D., P. P. Chase, M.D., F. E. McEvoy, M.D., A. Corvese, M.D., M. Adelman, M.D., P. C. Cook, M.D., C. W. Skelton, M.D., R. S. Wilcox, M.D., J. W. Sweeney, M.D., P. Appleton, M.D., W. Pickles, M.D.

For Councillor for two years: D. L. Richardson, M.D.

Dr. Henry J. Hoye, the President-elect, was escorted to the chair by Drs. Doten and Gibson. After a few remarks, he announced that he would appoint committees later.

After some adverse remarks from Dr. Kelly it was voted to give $175.00 to the R. I. Medical Society Library for the purchase of journals, $250.00 for binding journals and $450.00 donated to the R. I. Medical Society for any purpose desired. The annual dues were made $5.00.

The meeting adjourned at 9.30 P. M.

Attendance 47. Collation was served.

PETER PINEO CHASE
Secretary

PAWTUCKET MEDICAL ASSOCIATION

The regular monthly meeting of the Pawtucket Medical Association was held at the "Jack-O-Lantern," 33 Summer Street, Pawtucket on December 16, 1926.

A very instructive talk as given by Dr. C. H. Jameson of Providence.

Subject: Presenting Symptoms in Urology.

Collation was served.

LESTER J. GILROY
Secretary

ANNOUNCEMENT

SUPREME COURT UPHOLDS AMERICAN DRUGS

A decision of the highest importance to every physician, pharmacist, drug manufacturer and, in fact, every user of drugs in the United States was rendered by the Supreme Court of the United States on October 11, 1926, when this highest tribunal of the nation declared that the Chemical Foundation has been acting legally and properly in the purchase of the foreign drug and chemical patents, during the war, and licensing American manufacturers to produce these essential substances in this country.

The sale of the German patents to the Chemical Foundation took place during President Wilson's adminstration and had, without doubt, a distinct influence upon the outcome of the war, be-

cause this transfer permitted American concerns to begin at once the production of various drugs and chemicals which had, theretofore, been made only in Germany, and whose importation ceased with our entry into the war.

The next administration, apparently under some misapprehension as to the purposes and functions of the Chemical Foundation, directed that suit be brought by the government to set aside the sale of these patents to the Foundation.

The case was first tried in the Federal District Court of Wilmington, Del., and resulted, after weeks of evidence taking, in a finding against the government on all points.

The case was appealed to the Circuit Court, which upheld the decision of the District Court in every particular.

A final appeal carried the question to the Supreme Court of the United States, where evidence was heard more than a year ago. The long delay in rendering a decision has afforded time for mature consideration. The court has decided unanimously that the sale to the Chemical Foundation was valid and legal and that the Foundation has made no improper use of the powers which it thus acquired.

This decision is a momentous one for everyone who has anything to do with drugs and chemicals in any way whatever.

To the physician it means that he will have a steady and regular supply of reliable drugs, of American manufacturers, which can never again be upset or cut off by the vicissitudes of war. The same considerations apply to the pharmacists. Among the vitally necessary drugs affected may be mentioned the arsphenamines, cinchophen, barbital, the flavines, procaine and a host of others.

To the drug manufacturer, who has invested thousands of dollars in apparatus for the manufacture of drugs and chemicals under the Foundation's licenses, it means relief from a certain degree of anxiety (though the outcome of the case could scarcely have been in doubt) and a tremendous inspiration to further investigations looking to the production of more and better drugs and chemicals for America.

To the nation at large, it means that reliable medicines will continue to be sold at reasonable prices; and, more or less indirectly, that the dye industry of America, which is now in a flourishing condition, thanks to the Chemical Foundation, will be available for government uses should we become involved in another war.

Nor are medicine and pharmacy the only lines of endeavor affected by this momentous decision. The steel and packing industry and many others will be vastly benefited by the freedom of chemical investigation and activity which is now assured them.

MISCELLANEOUS

REMOVING SPLINTS AND BRACES FROM PATIENT

The literature is full of directions as to how and when to put the appliance on the patient. It is practically silent about removing it, and yet it requires good judgment to know when to divorce the patient from his splint, be it made of plaster, wood, leather or steel. Emil S. Geist, Minneapolis (*Journal A. M. A.*, August 14, 1926), pleads that authors of future textbooks on orthopedic surgery give more attention to the duration of disease and injury, especially as it affects the discontinuance of apparatus. He gives a table compiled by Dr. F. E. Clough of Lead, S. D., which is accurate and definite. It shows the number of days lost from work because of different kinds of fractures. Geist's rule for removing splints is simple: The use of a cast, brace or other appliance should not be discontinued abruptly; the patient should first be allowed to go without his apparatus for one hour daily for a week. The time should then be increased by making it two hours for the second week, three hours for the third week and so on. Frequently the process should be slowed down so that the gradual and definite removal of the appliance occupies a few months. This "hourly" method has several advantages: The patient does not feel that treatment is concluded as he is apt to if the brace is abruptly removed; he reports to the surgeon at stated intervals, at which times untoward symptoms of recurrence or relapse can be recognized. This method has proved especially valuable in those cases in which the discontinuance of the brace throws stress and strain on muscular groups that the physician is trying to "build up," as in infantile paralysis, weak-foot and scoliosis.